EXHIBIT H

SOUTH DAKOTA DEPARTMENT OF HUMAN SERVICES
DISABILITY DETERMINATION SERVICES
817 West Russell Suite 101
Sioux Falls SD 57104-1317
Phone/TDD: (605) 367-5499 or 1-800-658-2272
FAX: (605) 367-5485 or 1-800-658-3028

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02667 00000

January 23, 2002

JAN 25 2002

SSN:

Rob Lanpher, D.C.
506 N Sycamore Ave
Sioux Falls SD 57110-5737

MAILED
1-31-02

RE: Debbie Peterson-Bechtold
PO Box 3
Valley Springs, SD 57068-0003

DOB:

The above named person has applied for Social Security disability benefits due to fibromyalgia, detached retina, chronic neck and back pain, congenital defects in both wrist, bilateral calcaneal fractures and chronic pain.

Please submit copies of this person's records since 1/00 to the present.

- History, relevant clinical findings, diagnosis, treatment and response.
- Copies of consultative examinations.
- X-ray interpretations.
- Therapy/treatment notes.

You may submit copies of your records by mail or FAX. If there is a charge for this information, please submit a statement along with your report. Payment will be made in accordance with fees allowable under the SD Medicaid Program. Effective 11/1/99, this office will no longer be responsible for charges received later than 90 days after the date of this letter. Thank you for your assistance.

PLEASE RETURN THIS LETTER WITH YOUR REPLY

Mary M. Reiter Ext. 117
Claims Examiner
Enc: Medical release/Return envelope
101/MMR

TO BE COMPLETED BY SSA

NUMBER HOLDER

SOCIAL SECURITY NUMBER

EMPLOYEE/CLAIMANT/BENEFICIARY *(If other than Number Holder)*

AUTHORIZATION FOR SOURCE TO RELEASE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

INFORMATION ABOUT MEDICAL OR OTHER SOURCE PLEASE PRINT, TYPE OR WRITE CLEARLY

NAME AND ADDRESS OF SOURCE *(Include Zip Code)*
506 N. Sycamore Sioux Falls SD 57110 Dr. R. Lanpher
Lanpher Chiropractic

RELATIONSHIP TO DISABLED PERSON

INFORMATION ABOUT DISABLED PERSON PLEASE PRINT, TYPE OR WRITE CLEARLY

NAME AND ADDRESS *(If known)* AT TIME DISABLED PERSON ~~SOURCE (Include Zip Code)~~
Peterson-Bechtold, Debbie MMR
Valley Springs SD 57068-0000
DOB:

DATE OF BIRTH

DISABLED PERSON'S I.D. NUMBER *(If known and different than SSN)* *(Clinic/Patient No.)*

ON'S CONTACT WITH SOURCE *(e.g., dates of*

TO BE COMPLETED BY DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF

GENERAL AND SPECIAL AUTHORIZATION TO RELEASE MEDICAL AND OTHER INFORMATION IN ACCORDANCE WITH THE PROVISIONS OF THE SOCIAL SECURITY ACT; THE PUBLIC HEALTH SERVICE ACT, SECTIONS 523 AND 527; AND TITLE 38 U.S.C. VETERANS BENEFITS, SECTION 4132.

I hereby authorize the above-named source to release or disclose to the Social Security Administration or State agency the following information for the period(s) identified above:

1) All medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my impairment(s), including psychological or psychiatric impairment(s), drug abuse, alcoholism, sickle cell anemia, human immunodeficiency virus (HIV) infection (including acquired immunodeficiency syndrome (AIDS) or tests for HIV), or sexually transmitted diseases;
2) Information about how my impairment(s) affects my ability to complete tasks and activities of daily living;
3) Information about how my impairment(s) affected my ability to work.

I DO NOT authorize the use of a telefax or photocopy of this form for the release or disclosure of the information described above.

I understand that this authorization, except for action already taken, may be voided by me at anytime. If I do not void this authorization, it will automatically end when a final decision is made on my claim. If I am already receiving benefits, the authorization will end when a final decision is made as to whether I can continue to receive benefits.

READ IMPORTANT INFORMATION ON REVERSE BEFORE SIGNING FORM BELOW.

SIGNATURE OF DISABLED PERSON OR PERSON AUTHORIZED TO ACT IN HIS/HER BEHALF	RELATIONSHIP TO DISABLED PERSON (If other than self)	DATE
[signature]	self	01-17-02

STREET ADDRESS	TELEPHONE NUMBER (Area Code)
P.O. Box 3	605-757-7007

CITY	STATE	ZIP CODE
Valley Springs	SD	57068

The signature and address of a person who either knows the person signing this form or is satisfied as to that person's identity is requested below. This is not required by the Social Security Administration, but without it the source may not honor this authorization.

SIGNATURE OF WITNESS	STREET ADDRESS	
CITY	**STATE**	**ZIP CODE**

Form SSA-827 (1-1997) Use Prior Editions EF(3-99) (OVER)

PLTF 01009

SD DISABILITY DETERMINATION SERVICES -- DMA CLAIM COVER PAGE - MER
Phone: (605) 367-5499 or 1-800-658-2272

ROB LANPHER, D.C.
506 N SYCAMORE AVE
SIOUX FALLS, SD 57110-5737

REPLY TO:

DISABILITY DETERMINATION SVS
811 E 10TH ST DEPT 24
SIOUX FALLS SD 57103

APPLICANT: DEBBIE L PETERSON

YOU MAY REPLY BY FAX or MAIL.

***FAX*: # Pages faxed for above applicant (including this Cover Page):_____**
Send Records to SD DDS FAX #: 1-866-462-5904.
Use This Page as your Transmission Cover Page. If your business FAX cover sheet is necessary, place it under this page.

*** or ***

***MAIL*: SEND BY MAIL USING THE ENCLOSED RETURN ENVELOPE.**

INSTRUCTIONS FOR FAX OR MAIL:

- **THIS PAGE MUST BE ON TOP OF YOUR REPORT.** It provides the File Association Barcode for directing electronic records to the proper casefile. Necessary provider and applicant information is identified by this page.
- If faxing or mailing reports on more than one person, place this page for each applicant on top of his/her records.
- Mailed reports go to an electronic scanning contractor or DDS, per enclosed Business Reply envelope.
- If you have questions regarding this new process, please call Brenda Tibbetts @ 605-367-5499 x112.

RQID: 20051118400021 SITE: S47 DR: F
SSN: 478787267 DOCTYPE: 0001 RF: P CS: 74fc

SD-DDS DMA MER COVER PAGE (11/04R) SANDI C.

MAILED
11/30/05

PLTF 01010

This Authorization is Valid Only if Signed in Red Ink Authorization for Lanpher Chiropractic

Lanpher Chiropractic
DR. Robin Lanpher
506 N. Sycamore Avenue
Sioux Falls SD 57110

Form Approved OMB No. 0960-0623

WHOSE Records to be Disclosed

NAME (First, Middle, Last) Debbie Lynn Peterson (Peterson-Bechtold)

SSN _ _ Birthday (mm/dd/yy)

SSA USE ONLY NUMBER HOLDER (If other than above)

NAME

SSN - -

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW **

I voluntarily authorize and request disclosure (including paper, ~~oral, and electronic interchange~~):

OF WHAT ***All my medical records;*** **also education records and other information related to my ability to perform tasks. This includes specific permission to release:**

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s)** ***including,*** **and not limited to:**
   - **Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)**
   - **Drug abuse, alcoholism, or other substance abuse**
   - **Sickle cell anemia**
   - **Records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS); and tests for HIV.**
   - **Gene-related impairments (including genetic test results)**
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
4. **Information created within** ~~6~~ (6 (SIX)) **months after the date this authorization is signed, as well as past information.**

FROM WHOM

- **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM **The Social Security Administration and to the State agency authorized to process my case** (usually called "disability determination services"), **including contract copy services, and doctors or other professionals consulted during the process.** [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE Determining my **eligibility for benefits,** including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am **capable of managing benefits ONLY** (check only if this applies)

EXPIRES WHEN This authorization is good for ~~6~~ (6 (SIX)) months from the date signed (below my signature).

- ~~I authorize the release of a copy (including electronic copy) of this form for the disclosures and the information described above.~~
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

PLEASE SIGN USING BLUE OR BLACK INK ONLY

INDIVIDUAL authorizing disclosure

SIGN ▶ [signature]

IF not signed by subject of disclosure, specify basis for authority to sign

☐ **Parent of minor** ☐ **Guardian** ☐ **Other personal representative (explain)**

(Parent/guardian/personal representative sign here if two signatures required by State law) ▶

Date Signed	Street Address		
November 12, 2005	804 Cliff Avenue		
Phone Number (with area code)	**City**	**State**	**ZIP**
605-757-7007	Valley Springs	SD	57068

WITNESS *I know the person signing this form or am satisfied of this person's identity:*

SIGN ▶

Phone Number (or Address)

IF needed, second witness sign here (e.g., if signed with "X" above)

SIGN ▶

Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.